MIDLAND BEHAVIORAL HEALTH - 3450 RT. 60 EAST - BARBOURSVILLE, WV 25504

PATIENT INFORMATION SHEET

Patient Name:
first name middle last name

Date of birth: Age: Sex: SS#

Street Address:

City, State, Zip

Home phone: Work phone:

Mobile: Emergency Contact: Name: Phone #:

Occupation: Marital Status: S M W D SEP

Guardian Info (if under age 18)
first/last name of Guardian

Date of birth: Age: Sex:

Street Address:

City, State, ZIP

Home phone: Work phone:

Mobile: Pager:

Occupation:

Employer Name & Address:

Employer Telephone:

Health Insurance Info: LIST PRIMARY INSURANCE HERE & use next page to list other insurances)

Carrier Name:

Carrier address: Carrier Telephone:

Insured's Name: DOB:

Insured's Address:

Insured's Telephone: SS#

Employer Name & Address:

Employer Telephone:

Group number: Subscriber number:

DRUG ALLERGIES

MIDLAND BEHAVIORAL HEALTH - 3450 Rt. 60 East - Barboursville, WV 25504

PATIENT INFORMATION SHEET

Patient Name: first name middle last name

Health Insurance Info: **SECONDARY INSURANCE INFORMATION**

Carrier Name:

Carrier address: Carrier Telephone:

Insured's Name: DOB:

Insured's Address:

Insured's Telephone: SS#

Employer Name & Address:

Employer Telephone:

Group number: Subscriber number:

Health Insurance Info: **TIERIARY INSURANCE INFORMATION**

Carrier Name:

Carrier address: Carrier Telephone:

Insured's Name: DOB:

Insured's Address:

Insured's Telephone: SS#

Employer Name & Address:

Employer Telephone:

Group number: Subscriber number:

I hereby authorize the release of any medical information necessary to process any insurance claims and/or payments. initials

I authorize assignment of my benefits so that payment of any and all insurance benefits be made on my behalf directly to the physician's office. initials

Signature of Patient (Parent/Guardian if a minor) Date

Signature of Patient (12 year old and older) Date

Initials/date of Witness

MIDLAND BEHAVIORAL HEALTH

CONSENT / PAYMENT AGREEMENT / RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

Patient Name_____

I hereby consent to examination and/or treatment as recommended by the professional staff of this office. _____ (initials)

I accept responsibility for payment of all charges and fees for professional services on the above named patient. I understand that non-payment of my account balance may result in the use of collection/legal action in an attempt for this office to obtain payment for services rendered. I understand that any non-payment may result in physician termination of services with me. Termination of services may also occur if it is determined that the client is uncooperative with treatment, fails to keep scheduled appointments, abuse of medications, and leaving inpatient treatment against medical advice etc. _____ (initials)

I authorize any insurance benefits that are reimbursable for services to be paid directly to this office. I consent to the release and disclosure of all or any part of my medical records to any applicable professional or private review organizations and to my insurance company. This office will bill your insurance carrier on your behalf for charges incurred; however, you are responsible for the full amount of your account (with the exception of certain government insurance plans). _____ (initials)

I understand that an automated reminder system may be used a reminder for the next appointment. This is strictly a courtesy and in the event you do not receive a reminder, it does not relieve you of keeping your appointment or in giving at least a 24 hour notice of cancellation. Failure to give the required notice may result in charges for non-cancellation of appointment time. _____ (initials)

I received a copy of this office's Notice of Privacy Practices. _____ (initials)

_____ _____

Signature of Patient (12 years and older – patient must sign) Date

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are

This Notice describes the privacy practices of MIDLAND BEHAVIORAL HEALTH. It applies to the health services you receive our facility. **We will share your health information among ourselves to carry out our treatment, payment, and health care operations.**

II. Our Privacy Obligations

The law requires us to maintain the privacy of certain health information called **"Protected Health Information" ("PHI").** Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice.

III. Ways We Can Use and Share Your PHI Without Your Written Permission (Authorization)

In many situations, we can use and share your PHI for activities that are common in many hospitals and clinics. In certain other situations, which we will describe in Section IV below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Health Care Operations." These three terms are defined as:

- **Treatment.** We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

- **Payment.** We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your health care (**"Your Payor"**) and to confirm that Your Payor will pay for health care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.

- **Health Care Operations.** We may use and share your PHI for our health care operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other health care providers. In addition, we may share PHI with certain others who help us with our activities, including those we hire to perform services.

B. Your Other Health Care Providers. We may also share PHI with your doctor and other health care providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

C. Disclosure to Relatives, Close Friends and Your Other Caregivers. We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we (1) first provide you with the chance to object to the disclosure and you do not object; (2) infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

D. Public Health Activities. We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

1. to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
2. to report abuse and neglect to Human Services, or other government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;
3. to report information about products and services to the U.S. Food and Drug Administration;
4. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
5. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
6. to prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

G. Health Oversight Activities. We may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

H. Judicial and Administrative Proceedings. We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

I. Law Enforcement Purposes. We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

J. Decedents. We may share PHI with a coroner or medical examiner as authorized by law.

K. Organ and Tissue Procurement. We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

L. Research. We may use or share your PHI if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.

M. Workers' Compensation. We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

N. As required by law. We may use and share your PHI when required to do so by any other law not already referred to above.

IV. Uses and Disclosures Requiring Your Written Permission (Authorization)

A. Use or Disclosure with Your Permission (Authorization). For any purpose other than the ones described above in Section III, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

B. Marketing. We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials. However, we may communicate with you about products or services related to your Treatment, case management, or care coordination, or alternative treatments, therapies, health care providers, or care settings without your permission. For example, we may not sell your PHI without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including any portion of your PHI that is: (1) kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, Treatment and referral; (4) about HIV/AIDS testing, diagnosis or Treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) Invitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our HIPAA Program Office. You may also file written complaints with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. When you ask, the HIPAA Program Office will provide you with the correct address for the OCR. We will not take any action against you if you file a complaint with us or with the OCR.

B. Right to Receive Confidential Communications. You may ask us to send papers that contain your PHI to a different location than the address that you gave us, or in a special way. You will need to ask us in writing. We will try to grant your request if we feel it is reasonable. For example, you may ask us to send a copy of your medical records to a different address than your home address.

C. Right to Revoke Your Written Permission (Authorization). You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the HIPAA Program Office at the address below. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file, billing records, and other records used to make decisions about your Treatment and payment. If you want to access your records, you may obtain a record request form from us. If you request copies, we will charge you a search fee and a per page copied fee. We will also charge you for our postage costs, if you request that we mail the copies to you.

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in medical record files, billing records, and other records used to make decisions about your Treatment and payment for your Treatment. We will comply with your request unless we believe that the information that would be amended is correct and complete or that other circumstances apply.

F. Right to Receive an Accounting of Disclosures. You may ask for an accounting of certain disclosures of your PHI made by us.

H. Right to Receive Paper Copy of this Notice. If you ask, you may obtain a paper copy of this Notice, even if you have agreed to receive the notice electronically.

VI. Effective Date and Duration of This Notice

A. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice

Complaints about your privacy rights or how this practice has handled your health information should be directed to this office. If you are not satisfied with the manner in which we handle your complaint you may submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave S.W., Room 509F HHH Building, Washington, DC 20201.

B. Effective Date. This Notice is effective as of _____.

I HAVE READ THE Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this notice.

_____ _____

Patient's Name - (Print) Date

_____

Patient's Signature

_____ _____

Witnessed by (office staff) Date

MIDLAND BEHAVIORAL HEALTH
Coordination of Care Consent

Communication between MIDLAND BEHAVIORAL HEALTH providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

MIDLAND BEHAVIORAL HEALTH is authorized to release protected health information related to the evaluation and

treatment of _____ _____/_____/_____.
(Patient Name) (Date of Birth – MM/DD/YYYY)

PCP Name: _____ PCP Phone: _____

PCP Address: _____ _____
(Street) (City) (State) (Zip Code)

Other BH Provider Name: _____ BH Provider Phone: _____

BH Provider Address: _____ _____
(Street) (City) (State) (Zip Code)

Other Name: _____ Other Phone: _____

Other Address: _____ _____
(Street) (City) (State) (Zip Code)

___ **I do not have a Primary Care Physician (PCP).**

___ **I hereby refuse to give authorization for any release of information**

_____
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)
If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

MIDLAND BEHAVIORAL HEALTH

SCHEDULING/CANCELLATION POLICY

It is Midland Behavioral Health's policy that cancelation of appointments be made 24 hours prior to appointment date to allow our office to fill those time slots.

If there are two or more missed appointments without proper notification, this could result in discharge from the practice. If this occurs it will be addressed on an individual basis.

Scheduling multiple appointments in advance will no longer be allowed if an appointment is missed without proper notification and this will result in cancelation of all appointments that were scheduled in advance with **ALL** providers.

_____ _____

Signature of responsible party Date